DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		295083	B. WING _			C 03/05/2015	
	ROVIDER OR SUPPLIER HTS OF SUMMERLIN, L	rc		STREET ADDRESS, CITY, STATE, ZIP CODE 10550 PARK RUN DRIVE LAS VEGAS, NV 89144	•	33103/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	FO	000			
	a result of complaint your facility on 3/5/19 Code of Federal Reg - Requirements for L	eficiencies was generated as investigations conducted in 5, in accordance with 42 gulation Chapter IV, Part 483 ong Term Care Facilities.					
	The census at the tir The sample size was	ne of the survey was 183					
	•	1917 - The complaint					
	-	igative process was initiated alth Care Quality and 5.					
		ding Physician was not results was substantiated.					
	by the Division of Pu shall not be construe or civil investigation,	nclusions of any investigation blic and Behavioral Health and as prohibiting any criminal actions or other claims for allable to any party under ate, or local laws.					
F 505 SS=D	identified:	tory deficiencies were	F 5	005		4/15/15	
	The facility must prophysician of the findi	mptly notify the attending ngs.					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

03/20/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	295083	B. WING			02/	-
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2015
NAME OF PROVIDER OR SUPPLIER				0550 PARK RUN DRIVE		
THE HEIGHTS OF SUMMERLIN, LLC	С			AS VEGAS, NV 89144		
OLIMANA DV OTA	TEMENT OF DEFICIENCIES	l				0.450
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
by: Based on interview, cl documented review, th Physician was promptl results and cancellation were ordered. Findings included: Resident #1 Resident #1 was admit diagnoses including tra history of cerebral vaso hypertension and urina Resident #1's clinical re order dated 2/28/14, for C and S, anti-thrombin mutation, lupus anticoa anti-cardiolipin antibod performed by an outso Laboratory report from company printed on 3/ blood specimen was co AM, and received at th same day. The laboratory report of which included the foll - Cardio Homocystein: (umol/L). Reference ra - DRVVT (Dilute Russe laboratory test used for anticoagulant) screen:	linical record review and ne facility failed to ensure a ly notified of laboratory in of laboratory tests that Itted on 2/26/14, with ansient ischemic attack, cular accident, ary tract infection. Itecord revealed a laboratory or Factor V Leiden, protein III, prothrombin G 20210 A agulant, homocysteine and lies. The test were burced laboratory. In the outsourced laboratory (7/14, documented the ollected on 3/1/14 at 5:18 are laboratory at 8:50 AM the consisted in four (4) pages lowing documented results: 15.4 micromol per litter ange 0.0 - 10.3 umol/L. gell's viper venom time, a or detection of lupus Test not performed. Testing due to hemolysis.	F	505			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295083	B. WING		03/05/2015	
	NAME OF PROVIDER OR SUPPLIER THE HEIGHTS OF SUMMERLIN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10550 PARK RUN DRIVE LAS VEGAS, NV 89144	1 33/33/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 505	request Prothrombin Facto detected. The laboratory report	sult to follow. est canceled per client r II mutation: mutation not	F 50	5		
	results, who receive attending Physician faxed to the facility of	d the report and if the was notified. The report was on 3/7/15, six (6) days after was obtained, received by				
	progress notes) date 3/7/14, documented hypercoagulable sta documention indicat	s Note Forms (Physician ed 2/28/14, 3/4/14, 3/6/14 and the work up for the test was pending. The ed the attending Physician aboratory test results.				
	Request Form was f in-house laboratory verification of the Ph and S. The form did	AM, a Change of Order axed to the facility from the company requesting a sysician order for protein C not documented the cicient or was hemolyzed and				
	evidence of the follo -The attending Phys laboratory tests resu - The attending Phys DRVVT Screen test the specimen was	ician was notified about the llts. sician was notified the was not performed because a hemolyzed. sician was notified the tests				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NITIMBED:		IPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		295083	B. WING _			C 03/05/2015	
NAME OF PROVIDER OR SUPPLIER THE HEIGHTS OF SUMMERLIN, LLC				STREET ADDRESS, CITY, STATE, ZIP O 10550 PARK RUN DRIVE LAS VEGAS, NV 89144	ODE	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 505	reported to the face Physician. On 3/5/15 at 7:37 (DON) explained the laboratory compantests for the reside Charge Nurses reclaboratory results have the call would be received a laboratory results where we flagged in the clinic review. If results who tification should attending Physicia order was received laboratory report a DON verbalized if were obtained after the attending Physimmediately. On 3/5/15 at 10:42 Manager explained obtained after the nurses were respondent to the Case Month of the Case Manager was physician about at discharge, the Case results to the Prime On 3/15/15 at 11:4	age 3 rdiolipin anti-bodies were fility and/or to the attending AM, the Director of Nursing the facility had a contract with a sty to performed the laboratory onts. The DON indicated believed the results via fax. If any that a critical result, a telephone wed from the laboratory of the results via fax. If any that a critical result, a telephone wed from the laboratory of the Physician that record for the Physician that record for the Physician that it would be documented in the modern of the results. If a new that it would be documented in the abnormal results laboratory of the resident was discharged, the abnormal results laboratory of the resident was discharged, the mislies to contact the physician danager. The Health anager revealed it was not part the resident was discharged. If the sentified by nurses or a control of the physician that the province of the physician that the province of the physician was discharged. If the sentified by nurses or a control of the physician to follow up. 3 AM, the Laboratory that the physician to follow up.	F	505			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		295083	B. WING			C
NAME OF PROVIDER OR SUPPLIER THE HEIGHTS OF SUMMERLIN, LLC				STREET ADDRESS, CITY, STATE, ZIP COI 10550 PARK RUN DRIVE LAS VEGAS, NV 89144	•	03/05/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 505	outsourced laboratory process the tests order Physician. The Managand S test were cancel laboratory due to insuit issue was never communication between laboratory, the facility laboratory. The Manatoutsourced laboratory results for Factor V Leantithrombin II and process of Physical Nurse will follow up by the request on a telepolity Medicine) orders, nurses indicated, and to the Upon return of lab reserves.	company was used to be pred by the attending ger explained the protein C beled by the outsourced eled by the outsourced eled by the outsourced eled by the facility. The eled the second in the end the contracted and the outsourced eled the facility of the eled to the facility. The eled the contracted eled the contracted eled the contracted eled the facility of the eled the	F	505		